Office of State PERSONNEL NCFLEX℠

NCFlex Enrollment Form

Plan Year 2013

Effective Date: _____

EMPLOYING UNIT MUST COMPLETE

Payroll Unit Number: _____ New Employee: ☐ Yes ☐ No Date of Hire/Rehire (mo/day/yr): _____

Payroll Freq: (check ***one***) ☐ Monthly (12 checks per year) ☐ Semi-Monthly (24 checks per year) ☐ Bi-Weekly (26 checks per year) ☐ Bi-Weekly with monthly deductions (26 checks per year) ☐ Other Frequency: _____

EMPLOYEE INFORMATION (Please Print)

☐ Male ☐ Female

Name:(Last) _____ (First) _____ MI _____ Date of Birth: mm dd yy _____

SSN: _____ Daytime Phone: (area code) _____ Agency/Univ/Comm Col: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

FLEXIBLE SPENDING ACCOUNTS (FSAs)*

(TO CONTINUE YOUR FSA, YOU MUST RE-ENROLL EVERY YEAR)

Annual Health Care FSA Contribution: $_____
(**Annual** minimum $120; **Annual** maximum $2500)

Annual Dependent Day Care FSA Contribution: $_____
(**Annual** minimum $120; **Annual** maximum $5000)

***FSA payments are issued by Direct Deposit to the account your main payroll check is deposited.**

CANCER INSURANCE

☐ **New** ☐ **Change** ☐ **Cancel** **Submit EOI form, if required**

Plan Options (check one): ☐ LOW OPTION ☐ HIGH OPTION ☐ PREMIUM OPTION

Coverage Levels (check one): ☐ Employee Only ☐ Employee + Family

CRITICAL ILLNESS

☐ **New** ☐ **Change** ☐ **Cancel**

Coverage Levels (check one): ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family

DENTAL PLAN

☐ **New** ☐ **Change** ☐ **Cancel**

Plan Options (check one): ☐ LOW OPTION ☐ HIGH OPTION

Coverage Levels (check one): ☐ Employee Only ☐ Employee + One Child ☐ Employee + Two or More Children ☐ Employee + Spouse ☐ Family

VISION CARE PLAN

☐ **New** ☐ **Change** ☐ **Cancel**

Plan Options (check one): ☐ Plan 1: Exam & Materials ☐ Plan 2: Materials Only ☐ Plan 3: Enhanced Exam & Materials

Coverage Levels (check one): ☐ Employee Only ☐ Employee + Family

DEPENDENT INFORMATION

Name (Last, First, MI)	Gender M	Gender F	Date of Birth	Child is My	Complete Only if Child is Over 19	Add/Drop		NCFlex Plans Selected: Dental	Vision	Critical Illness	Cancer
Complete only if enrolling in Dental/Vision/Critical Illness/Cancer											
Spouse	☐	☐	/ /			☐	☐	☐	☐	☐	☐
Child (1)	☐	☐	/ /	☐ Natural ☐ Foster ☐ Adopted ☐ Step	☐ Full-Time Student ☐ Handicap	☐	☐	☐	☐	☐	☐
Child (2)	☐	☐	/ /	☐ Natural ☐ Foster ☐ Adopted ☐ Step	☐ Full-Time Student ☐ Handicap	☐	☐	☐	☐	☐	☐
Child (3)	☐	☐	/ /	☐ Natural ☐ Foster ☐ Adopted ☐ Step	☐ Full-Time Student ☐ Handicap	☐	☐	☐	☐	☐	☐
Child (4)	☐	☐	/ /	☐ Natural ☐ Foster ☐ Adopted ☐ Step	☐ Full-Time Student ☐ Handicap	☐	☐	☐	☐	☐	☐
Child (5)	☐	☐	/ /	☐ Natural ☐ Foster ☐ Adopted ☐ Step	☐ Full-Time Student ☐ Handicap	☐	☐	☐	☐	☐	☐

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

☐ **New** ☐ **Change** ☐ **Cancel** Complete Beneficiary at Right.

☐ Voluntary Plan 1 Employee Only
☐ Voluntary Plan 2 Employee & Family

Aviation Pilot/Crew Member, after you select your coverage option check this box. ☐

Insurance Amount _____ Monthly Cost $ _____

CORE ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

$10,000 No-Cost, Employee Only AD&D ☐ **New** ☐ **Cancel** Complete Beneficiary at Right.

GROUP TERM LIFE INSURANCE

Complete Beneficiary at Right and **Submit EOI form, if required**

☐ **New** ☐ **Change** ☐ **Cancel**

Insurance Amount _____ Monthly Cost $ _____

Note: If you need to add additional beneficiaries, please attach a separate sheet of paper and identify the benefit for which they are your beneficiary.

VOLUNTARY AD&D BENEFICIARY

Full Name(s)	RELATIONSHIP TO EMPLOYEE	% OF BENEFIT
Primary:		
Contingent:		

CORE AD&D BENEFICIARY

Full Name(s)	RELATIONSHIP TO EMPLOYEE	% OF BENEFIT
Primary:		
Contingent:		

TERM LIFE BENEFICIARY

Full Name(s)	RELATIONSHIP TO EMPLOYEE	% OF BENEFIT
Primary:		
Contingent:		

EMPLOYEE AUTHORIZATION

I hereby elect coverage under NCFlex as listed above for myself and eligible family dependents. I understand that by participating in NCFlex my Social Security Number will be used for tax identification purposes, and my pay will be reduced by the amount of my pre-tax elections. **I understand that, in accordance with IRS regulations, I cannot change or cancel my elections or contributions during the Plan Year unless I have a qualifying status change. I understand that any amounts contributed to the Flexible Spending Accounts, which I do not use for expenses incurred during the Plan Year will be forfeited.** I certify that the above information is true and accurate to the best of my knowledge.

Employee Signature: _____ Date: _____

Please make a copy for your records then return completed ORIGINAL form to your HBR or benefits department.

FORM 1 (2011)
S-125 = Y SITUS = NC